NEWBORN SCREENING CARD REPLACEMENT FORM

FACILITY NAME_____

ATTN: (DEPT) _____

ADDRESS _____

_____

CONTACT NAME_____

TELEPHONE # _____

NUMBER OF CARDS RETURNED FOR REPLACEMENT _____

CARD I.D. NUMBERS ON THE CARDS RETURNED

_____

_____

_____

_____

_____

FIN 324 (4/98) ATHY:PA 14 OF 1987

REMOVE THE FILTER PAPER FROM THE CARDS BEFORE SENDING TO THE ADDRESS BELOW. CARDS SENT IN WITH BLOOD SAMPLES ATTACHED WILL BE TESTED AND NO CREDIT WILL BE ISSUED.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH USE ONLY

NUMBER OF CARDS REPLACED: _____
REPLACEMENT CARD I.D. NUMBERS:

_____

FACILITY # _____ SALES ORDER # _____

ACCTG APPROVAL _____ DATE _____

PLEASE SEND CARDS TO BE REPLACED AND THIS FORM TO:

DEPARTMENT OF COMMUNITY HEALTH
ATTN: NEWBORN SCREENING
LEWIS CASS BLDG., 4TH FLOOR
320 S. WALNUT
LANSING, MI 48913